

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
- MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plane # 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X New Market		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First Melvin	Middle L. Anderson	Lost	4. DATE OF DEATH April 14	Month 1958	Day	Year
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 1, 1934	9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Purdum, Md.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Melvin Anderson	14. MOTHER'S MAIDEN NAME Anna Moore
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No 216-30-3489	17. INFORMANT Mrs Anna Anderson, New Market, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Hemorrhage due to cutting femoral artery left thigh		INTERVAL BETWEEN ONSET AND DEATH Minutes
(b) DUE TO Cutting femoral artery				
(c) left thigh				

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cut in left thigh during left femoral artery	
20c. TIME OF INJURY Hour 12:00 a. m. p. m. 4-14 1958	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		
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ACTUAL SIGNATURE B. L. Anderson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 16, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Grove	22d. LOCATION (City, town, or county) Purdum, Montg. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molyneux	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR APR 17 '58	24b. REGISTRAR'S SIGNATURE Albert E. Smith

BUREAU V. S.

APR 17 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 46^4 CERTIFICATE OF DEATH

04565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN 1b 28 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS Myersville 118	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Blanche Esta Baker		First	Middle
4. DATE OF DEATH April 10	Month	Day	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1877
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) Nr. Wolfsville		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Shuff		14. MOTHER'S MAIDEN NAME Sarah Stottlemeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Florence Bakrn		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage	
		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertension		(c) DUE TO Arterio Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middletown	
(County)		(State)	
21. I certify that I attended the deceased from Mar 20, 1958, to Apr 10, 1958, that I last saw the deceased alive on April 8, 1958, and that death occurred at 10 10 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Middletown, Md.	
ACTUAL SIGNATURE J. Elmer Hawk M.D.		DATE SIGNED 4-11-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/58	
22c. NAME OF CEMETERY OR CREMATORIUM United Brethren		22d. LOCATION (City, town, or county) Myersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Biddle Myersville, Md.		24a. REC'D. BY REGISTRAR APR 13 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE C. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S

APR 15 1939

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4572 CERTIFICATE OF DEATH

04566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon		13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) HOWARD		First C.	Middle .	Last BIDINGER	4. DATE OF DEATH APRIL 28, 1958	Month APRIL	Day 28	Year 1958	
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6-4-1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY gen.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Augustus R. Bidinger				14. MOTHER'S MAIDEN NAME Henriette Ritter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-03-0578		17. INFORMANT Mrs. Ethel J. Bidinger, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertensive cardiovascular disease 1 yr +						INTERVAL BETWEEN ONSET AND DEATH 2 hr.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick		(County)	(State)
21. I certify that I attended the deceased from 4/28, 1958, to 4/28, 1958, that I last saw the deceased alive on 4/28, 1958, and that death occurred at 7:30 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 4 E. Church St		DATE SIGNED 4/28/58	
ACTUAL SIGNATURE Henry V. Chase		M.D.							
PHYSICIAN'S NAME (Type) Henry V. Chase									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-1-1958		22c. NAME OF CEMETERY OR CREMATORIAL Morgan Chapel		22d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## 18 CERTIFICATE OF DEATH

Name of deceased		Age at time of death	
John H. Johnson		60 years	
Place of residence		Date of death	
1100 W. 36th Street, Baltimore, Maryland		July 1, 1968	
Cause of death		Time of death	
Cancer of the prostate		10:00 A.M.	
Time of examination		Signature of physician	
July 1, 1968		John H. Johnson	
Signature of physician		Title	
John H. Johnson		Physician	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4573

## CERTIFICATE OF DEATH

84567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>162 W; All Saints Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Roy</b>	Middle <b>Emory</b>	Last <b>Bowie</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>11</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 9- 1898</b>	9. AGE (in years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
7. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Bartonsville-Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emory C. Bowie</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9332</b>		17. INFORMANT <b>Margaret Diggs — 162 W. All Saints</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebral vascular accident (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-21</b> , 19 <b>57</b> , to <b>4-11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>58</b> , and that death occurred at <b>9:12 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E Church</b> DATE SIGNED <b>4-14-58</b>							
ACTUAL SIGNATURE <i>Rex R. Martin</i>	M.D.						
PHYSICIAN'S NAME (Type) <b>Rex R. Martin</b>	Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-14-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Bartonsville</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Frederick, Md.</b>				24a. REC'D BY REGISTRAR APR 15 1958		24b. REGISTRAR'S SIGNATURE <i>John E. Hicks</i>	
				DATE			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

## CERTIFICATE OF DEATH

BUREAU V. 2

APR 15 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04568

## 4574 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b Months <b>11</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>352 Park Avenue</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>Laura</b>		First <b>Laura</b>	Middle <b>SHEELER</b>
4. DATE OF DEATH <b>April 28, 1958</b>		Month <b>April</b>	Day <b>28</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 17, 1875</b>		9. AGE (In years lost birthday) <b>82</b>	10. IF UNDER 1 YEAR Months <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Conrad Shuler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Helen B. Lashlee, Washington 20, D.C.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr. 27, 1958</b> , to <b>Apr. 28, 1958</b> , that I last saw the deceased alive on <b>Apr. 28, 1958</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. H. Slusher</i>		ADDRESS (Street, city or town, state) <b>East Church Street, Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Bush Creek Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick County, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 2 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Al. Etchison</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04569

## 4675 CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN 1b <b>807</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		d. STREET ADDRESS <b>1227 Hollins St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James</b>	First	Middle	Last	4. DATE OF DEATH <b>April</b>	Month	Day	Year <b>10 19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 24, 1905</b>	9. AGE (In years lost birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Brewer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Spence</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>136-14-2506</b>		17. INFORMANT <b>Records of Victor Cullen Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X</b> <b>Cardio-respiratory failure</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <b>Far Advanced active pulmonary tuberculosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <b>1/24/56</b> , 19, to <b>4/10/58</b> , 19, that I last saw the deceased alive on <b>4/9/58</b> , 19, and that death occurred at <b>10:10 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>Michael G. Zavis</i>	M.D.						
PHYSICIAN'S NAME (Type) <b>Michael G. Zavis, M. D., Cullen, Frederick County, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>Apr. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peters Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore,</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Granger - Thompson</i>		ADDRESS <i>1227 Hollins St.</i>		24a. REC'D BY REGISTRAR DATE <b>Apr 14 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Asst. Sec. 1</i>	

RECEIVED  
APR 14 1959  
BURAU Y. S

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		4676 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b>		c. LENGTH OF STAY IN 1b <b>several yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>700 East South St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roger Jonathan Brightwell</b>		First <b>Roger</b>	Middle <b>Jonathan</b>	4. DATE OF DEATH <b>April 7th 1958</b>	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. <del>Married</del> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 29-1910</b>	9. AGE (In years less birthday) <b>48 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jonathan C. Brightwell</b>		14. MOTHER'S MAIDEN NAME <b>Elsie May Kemp Brightwell</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-0770</b>		17. INFORMANT Address <b>Mrs. Kohlman Miller-700 E. South St.-Frederick</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>None</b>		DUE TO (c) <b>None</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Ed. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>April 8-1958</b>	
EXAMINER'S NAME (Type) <b>C. E. Cline &amp; Son</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4-9-1958</b> 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Olivet Cemetery</b> 22d. LOCATION (City, town, or county) <b>Frederick Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>APR 9 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Albert Leach</b>			

BUREAU Y. S

APR 9 1959

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 90 I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04571

4575 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cutchey Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middletown</i>	
3. NAME OF DECEASED (Type or print) <i>Anna</i>		d. STREET ADDRESS <i></i>	
4. DATE OF DEATH Month <i>4</i>	Day <i>6</i>	Year <i>1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-1882</i>
9. AGE (In years lost birthday) yrs. <i>76</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>Charles Cruse</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Bissell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Richard E. Brown, Frederick RFD2, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <i>Coronary Occlusion</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec</i> , 19 <i>57</i> , to <i>Apr 6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Apr 5</i> , 19 <i>58</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Elmer Harp</i>		ADDRESS (Street, city, or town, state) <i>Middletown</i>	
PHYSICIAN'S NAME (Type) <i>J. Elmer HARP</i>		DATE SIGNED <i>4-6-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-8-1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co., Middletown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 9 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

## BUREAU

APR 9 1958

## РЕГЕЛИВ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04572

4576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 248 South Carroll Street		d. STREET ADDRESS 248 South Carroll Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle ALBERT	Last CASTLE
4. DATE OF DEATH	Month April	Day 17,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 6, 1878
9. AGE (In years at birth) 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	10b. KIND OF BUSINESS OR INDUSTRY Theatre	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Abram P. Castle	14. MOTHER'S MAIDEN NAME Jane Rebecca DeGrange	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-26-2212	17. INFORMANT Mrs. Anna M. Castle—Same as item #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days 4 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1952, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 2:00A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>James B. Thomas</i> M.D. Professional Building, DATE SIGNED 4/17/1958			
PHYSICIAN'S NAME (Type) Dr. James B. Thomas	Frederick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 19, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 21 '58	24b. REGISTRAR'S SIGNATURE <i>Quinton</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

APR 21 1958

BEREAVY X. S.

APR 21 1958

REGISTRY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4697 CERTIFICATE OF DEATH

04573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middletown</i>		c. LENGTH OF STAY IN 1b <i>5 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middletown</i>	
3. NAME OF DECEASED (Type or print) <i>Ervin R</i>		d. STREET ADDRESS <i>1</i>	
4. DATE OF DEATH <i>4 10 1958</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-16-1892</i>	
WIDOWED <input type="checkbox"/>		9. AGE (In years lost birthday) <i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>private</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>John T. Cline</i>		14. MOTHER'S MAIDEN NAME <i>Anna Denbieris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W. I 220-09-7665</i>	
17. INFORMANT <i>Ervin T. Cline Middletown, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Coronary Occlusion</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchial Asthma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar 16 1958</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>4:30 A. M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Jefferson Md</i>	
ACTUAL SIGNATURE <i>Dr. A. T. Brice</i>		DATE SIGNED <i>4/1/58</i>	
PHYSICIAN'S NAME (Type) <i>Dr. A. T. Brice</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/13/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) <i>Middletown Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co., Middletown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 15 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Ab. Leach</i>	

## 4805 CERTIFICATE OF DEATH

RECEIVED  
APR 15 1938  
BUREAU V. 1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4577 CERTIFICATE OF DEATH

14574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>FREDERICK</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FREDERICK</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>35 Maryland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MEMORIAL HOSPITAL</i>		d. STREET ADDRESS <i>330 west potomac street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Jane</i>	Last <i>Clipp</i>	4. DATE OF DEATH <i>April 29 1958</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>6-11-1932</i>	9. AGE (In years last birthday) <i>25</i>	IF UNDER 1 YEAR yrs. <i>Months Days Hours Min.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
13. FATHER'S NAME <i>Russell Tritipoe</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Main</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Cecil Clipp, Brunswick, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>953 X</i>		DUE TO <i>Anaphylactic Reaction generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Due to sulfamethoxypyridazine</i>					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/29</i> , 19 <i>58</i> , to <i>4/29</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4/29</i> , 19 <i>58</i> , and that death occurred at <i>5:30</i> P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>4 Elliot Church St</i>	
ACTUAL SIGNATURE <i>Henry V Chase</i>		M.D.				DATE SIGNED <i>4/30/58</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-2-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Brethren</i>		22d. LOCATION (City, town, or county) <i>Brownsville, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Felt</i>		ADDRESS <i>Brunswick, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. French</i>	

81 3801114-0000150 3801114-0000150 3801114-0000150

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

tem 20 Film 228 4-22-58 a.m. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		4678		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Route 144</b>		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - P.O. - Mt. Airy-</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Shirley</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 11th 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <b>Widow</b>	B. DATE OF BIRTH <b>Nov. 16-1913</b>	9. AGE (In years last birthday) <b>44 yrs.</b>	Month Day Year IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bridge work</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Tivis Collins</b>		14. MOTHER'S MAIDEN NAME <b>Dolly Livesay</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <b>227-36-6364</b>		17. INFORMANT <b>Mrs. Shirley C. Collins-Mt. Airy-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Broken Neck -</b> <b>812X</b> DUE TO <b>Compound fracture of right leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Turn from joint</b> (c) <b>House - Multiple fracture of left leg</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Cause of death was PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by hit &amp; run driver dragged about 60 feet</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>7 p.m.</b> 4-11 1958		20d. INJURY OCCURRED While <b>Not while</b> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rte 144 mile East of NewMarket Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B.O.Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4-12-1958</b>	
EXAMINER'S NAME (Type) <b>B.O.Thomas</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sharon Baptist Cemetery</b>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22d. DATE THEREOF <b>4-15-1958</b>		22d. LOCATION (City, town, or county) <b>Nr. West Friendship-Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Cline &amp; Son</b>		ADDRESS <b>Frederick-Maryland</b>		24c. REC'D BY REGISTRAR DATE <b>APR 15 '58</b>	
				24d. REGISTRAR'S SIGNATURE <b>Albert Leacock</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Knoxville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Cora	Middle M.	Lost Cooper	4. DATE OF DEATH Month 4	Day 2	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/20/1879		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin McBride				14. MOTHER'S MAIDEN NAME Elizabeth Ausherman		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Dennis R. Cooper, Knoxville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Influenza				INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senile Psychosis					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20, 1958 to 4/2, 1958, that I last saw the deceased alive on 4/2, 1958, and that death occurred at 7 M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. W. B. Carpenter				ADDRESS (Street, city or town, state) Bushnell, Md.		DATE SIGNED 4/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/5/1958		22c. NAME OF CEMETERY OR CREMATORIUM Knoxville Cemetery		22d. LOCATION (City, town, or county) (State) Knoxville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE Westrauch	

## CERTIFICATE OF DEATH

SAC-747-10

BUREAU V.

APR 7 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4578

## CERTIFICATE OF DEATH

04577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>57 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>126 South Market Street</b>		11. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>Blanche</b>		First <b>Blanche</b>	Middle <b>Louise</b>
4. DATE OF DEATH <b>April</b>		Last <b>Eader</b>	Month <b>21</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>
8. DATE OF BIRTH <b>May 6-1873</b>		9. AGE (In years lost birthday) <b>84 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Goodman</b>	
14. MOTHER'S MAIDEN NAME <b>Louise Pratt Goodman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Bernard A. Crutchley-126 S. Mkt. St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <b>4/16</b> , 1958, to <b>4/21</b> , 1958, that I last saw the deceased and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>James B. Thomas</b>		ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>4-22-58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-24-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick-Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR <b>APR 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - GENERAL SALVATION OF THE STATE OF DEATH

**BUREAU Y. S.**

APR 24 1958

REGEV

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4579 CERTIFICATE OF DEATH

Reg. Dist. No.

04578

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Loudoun</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lovettsville-Rural-R.D.#1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>83X-3</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ROBERT</b>	Middle <b>SYLVESTER</b>	Last <b>ENGLISH</b>	
4. DATE OF DEATH	Month <b>April</b>	Day <b>27</b>	Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Arthur English</b>		14. MOTHER'S MAIDEN NAME <b>Cathdrine Smith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>210-26-8829</b>	17. INFORMANT <b>Mrs. Wilmer Frye, Lovettsville R.F.D.#2, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		<b>Acute coronary thrombosis</b> <b>2 WKS</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <b>Anterior descending Heart disease</b>		<b>5 years T</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/24/1958</b> to <b>4/27/1958</b> , that I last saw the deceased alive on <b>4/27/1958</b> , and that death occurred at <b>3:10 A.M.</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Henry V Chase</b> M.D. <b>East Church Street</b> ADDRESS (Street, city or town, state) <b>Frederick, Maryland</b>				DATE SIGNED <b>4/28/58</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Union Cemetery</b>	22d. LOCATION (City, town, or county) <b>Lovettsville, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. ADDRESS <b>Frederick, Maryland</b>	24b. REC'D BY REGISTRAR <b>APR 29 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Etchison</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU X.

APR 29 1958

RECEIVED

## 4580 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 14 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home				d. STREET ADDRESS 561 East Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle EDWARD	Lost ESWORTHY	4. DATE OF DEATH April 18, 1958	Month April	Day 18	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 3 Sept 1874	9. AGE (In years (on birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Night watchman		10b. KIND OF BUSINESS OR INDUSTRY Grocery Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Amos A. Esworth		14. MOTHER'S MAIDEN NAME Matilda O'Hara						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-5190		17. INFORMANT C. Oliver Esworth (Same as item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Arterio Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 5 Years		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO								
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick, Maryland		(County) (State)
21. I certify that I attended the deceased from alive on April 15, 1958, and that death occurred at 9:30A M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>H. J. Slusher, M. D.</i>						DATE SIGNED 4-18-58		
PHYSICIAN'S NAME (Type) H. J. Slusher, M. D.				Frederick, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Etchison</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 31. BROWNIAS-PTASZI DO TAKMICOVANIA I WYKONIWANIA

## BUREAU V.

APR 21 1958

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4581

## CERTIFICATE OF DEATH

Reg. Dist. No.

04580

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick	
Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 1/2 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RD 4	
Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Margaret		A.	Everly
4. DATE OF DEATH		Month	Day
April 25 1958		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	B. DATE OF BIRTH Nov. 7 1897
9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
60 yrs.		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		home	Maryland
12. CITIZEN OF WHAT COUNTRY?		H. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Otis Layman		Eda Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		NONE	Albert W. Everly - same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
443X Cerebral Hemorrhage		1 wk	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
(b) Hypertensive cardiovascular disease		2 yrs	
DUE TO			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Doy, Year	20d. INJURY OCCURRED
Hour o. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p. m.		19	20f. (City or town)
			(County)
			(State)
21. I certify that I attended the deceased from		4/25	1958, to
olive on		4/25	1958, and that death occurred at 8:30 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
Henry V. Chase M.D.		415 Church St 4/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
Burial		4-28-1958	Locust Grove
22d. LOCATION (City, town, or county)		(State)	
Frederick Co. Md.		Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
John M. Waltz, Winfield, Md.		DATE APR 29 '58	
24b. REGISTRAR'S SIGNATURE		Albert Everly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 | STATE OF THE ENVIRONMENT REPORT

BUREAU V. S.

APR 29 1958

PEGEIY EO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4582

## CERTIFICATE OF DEATH

Reg. Dist. No.

04581

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		d. STREET ADDRESS <i>Route #1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Martin Cleveland Eyer</i>	First	Middle	Last
4. DATE OF DEATH <i>April 15 1958</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 1, 1894</i>
9. AGE (In years last birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>FREDERICK Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>HENRY W. EYER</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH Wetzl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>180-22-3530</i>	
17. INFORMANT <i>Miss. Martha Eyer</i>		Address <i>Emmitsburg, R.D.#1, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Hemorrhage</i>			
DUE TO (c) <i>Hypertensive Vascular Disease</i>		3 years	
DUE TO (c) <i>Arteriosclerosis, generalized</i>		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Emmitsburg, Md.</i> (State) <i>MD</i>	
21. I certify that I attended the deceased from <i>4/12/58</i> , 1958, to <i>4/15</i> , 1958, that I last saw the deceased alive on <i>4/15</i> , 1958, and that death occurred at <i>730P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V. Chase</i>		ADDRESS (Street, city or town, state) <i>4 E. Church St, Frederick Md.</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		DATE SIGNED <i>4/15/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/19/1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Friends Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Emmitsburg, R.D.# 1, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. L. Allison</i>		ADDRESS <i>Emmitsburg, Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arch. edward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DESIGN

APR 18 1958

BUREAU OF INVESTIGATION

APR 18 1958



BUREAU OF INVESTIGATION

APR 18 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04582

## 4583 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>39 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 West Patrick St.</b>				d. STREET ADDRESS <b>124 West Patrick St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>V.</b>	Middle <b>Fischer</b>	Last <b></b>	4. DATE OF DEATH <b>April 11th</b>	Month <b>1958</b>	Day <b></b>	Year <b></b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. B. DATE OF BIRTH <b>Feb. 8-1902</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mfg. Auto Batteries</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Clarence M. Wright</b>				14. MOTHER'S MAIDEN NAME <b>Alice Van Pelt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-7553</b>		17. INFORMANT <b>John Francis Fischer-Jr. - Frederick-Maryland</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2</b>		DUE TO <b>Stomach cell carcinoma involving liver, gall bladder &amp; mesentery.</b>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Exploratory laparotomy - Confirmed diagnosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>Apr 11</b> , 1958, to <b>Apr 11</b> , 1958, that I last saw the deceased alive on <b>Apr 11</b> , 1958, and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b></b>		
ACTUAL SIGNATURE <b>H.F.Kline</b>			M.D. <b></b>		DATE SIGNED <b></b>			
PHYSICIAN'S NAME (Type) <b>Dr. H.F.Kline</b>							Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-11-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Frederick Mem. Park</b>		22d. LOCATION (City, town, or county) <b>W. of Frederick-Maryland</b>		(State) <b></b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Cline &amp; Son</b>	ADDRESS <b>Frederick-Md.</b>			24a. REC'D BY REGISTRAR <b>APR 15 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Albert E. Cline</b>			

## CERTIFICATE OF DEATH

RECEIVED  
APR 15 1958  
BURLAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04583

4610

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
3. NAME OF DECEASED (Type or print)		First <b>Lester</b>	Middle <b>Cleveland</b>
4. DATE OF DEATH		Month <b>April</b>	Day <b>20</b>
5. SEX		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 30, 1887</b>		9. AGE (in years last birthday) <b>70</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick C. Fisher</b>	
14. MOTHER'S MAIDEN NAME <b>Mellie Colliflower</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Cera S. Fisher</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Coronary type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 12</b> , 19 <sup>58</sup> to <b>Apr. 20</b> , 19 <sup>58</sup> that I last saw the deceased alive on <b>Apr. 20</b> , 19 <sup>58</sup> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b>	
ACTUAL SIGNATURE <b>James K. Gray</b>		DATE SIGNED <b>Apr. 25 '58</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>Apr. 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert J. Schuck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

51. **STATEMENT OF EXPENDITURE OF DEPARTMENTAL QUADRANT**

# BUREAU V. S.

APR 25 1959

# РЕГЕИВ ЕД

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04584

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	4611 Frederick	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Adamstown	c. LENGTH OF STAY IN 1b Since 12/1902	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Adamstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First RUTH	Middle EMMA	Last GIBSON	4. DATE OF DEATH Month April Day 7, 1958
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 16 Oct 1891	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John H. Ogle	14. MOTHER'S MAIDEN NAME C. Rebecca Madery
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT B. Clark Gibson, Sr. (Same as item #1)	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 2 months
420.1	DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
	DUE TO (c)		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--	--	--

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 4-7-58
--	--	-----------------------

EXAMINER'S NAME (Type) B. O. Thomas, M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
--	---

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-10-58	22c. NAME OF CEMETERY OR CREMATORIAL Frederick Memorial Park	22d. LOCATION (City, town, or county) Frederick, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR APR 9 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Etchison</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

RECEIVED - MAIL ROOM - DEPARTMENT OF HOMELAND SECURITY - WASHDC - 20530-12

BUREAU V. S.

APR 9 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04585

## 4612 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick MARYLAND		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 311 West Potomac St.		d. STREET ADDRESS 311 West Potomac Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Silas	Middle Stickley
Last Goode		4. DATE OF DEATH 4	Month 8
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B.&O.R.R.CO		10b. KIND OF BUSINESS OR INDUSTRY Transportation	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Strother R. Goode		14. MOTHER'S MAIDEN NAME Helen V. Stickley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Hazel Goode
		Address Bruhswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Coronary Occlusion	
(b) DUE TO		Coronary Occlusion 2 yrs	
(c) DUE TO		Hypertension 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a. Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 19</u> to <u>July 19</u> , 1958, that I last saw the deceased alive on <u>July 19</u> , 1958, and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. G. F. Smith</i>		ADDRESS (Street, city or town, state) M.D. Brunswick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-1958	22c. NAME OF CEMETERY OR CREMATORIAL Union
22d. LOCATION (City, town, or county) Lovettsville		(State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. J. Festa</i>		24a. REC'D BY REGISTRAR APR 14 '58	24b. REGISTRAR'S SIGNATURE <i>Ch. J. Festa</i>
ADDRESS Brunswick, Maryland		DATE	

## 103 CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4584 CERTIFICATE OF DEATH

14586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3		d. STREET ADDRESS Yellow Springs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOHN	Middle EDWARD	Lost HARPER	4. DATE OF DEATH April 8, 1958	Month April	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Unk	9. AGE (In years less birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Harper			14. MOTHER'S MAIDEN NAME Mary Stottlemeyer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-2348		17. INFORMANT Mrs. Ella M. Lods, Frederick, Md.		5 Mt. Olivet Blvd., Frederick, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 3 mos. 2 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Jan</u> , 1958, to <u>Apr</u> , 1958, that I last saw the deceased alive on <u>Apr 8</u> , 1958, and that death occurred at <u>7:45 PM</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. F. Kline</u>						ADDRESS (Street, city or town, state) 7 N. Market St. DATE SIGNED 4-10-58		
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.		Frederick, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Lutheran Cemetery		22d. LOCATION (City, town, or county) Frederick County Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE <u>Q. 1. 1. 1.</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4585 CERTIFICATE OF DEATH

04587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>11</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>West 4th Street Ext.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Monaview County Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Ellen</b>	Last <b>XXXXX Harper</b>	4. DATE OF DEATH <b>April</b>	Month <b>4</b>	Day <b>19</b>	Year <b>58</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>75 ? yrs.</b>	10. IF UNDER 1 YEAR Months <b>75</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>1 m</b>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frederick</b>	(County) <b>Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from _____, 19 <sup>57</sup> , to _____, 19 <sup>58</sup> , that I last saw the deceased alive on _____, 19 <sup>58</sup> , and that death occurred at _____, 19 <sup>58</sup> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick Md.</b>									
ACTUAL SIGNATURE <i>H. F. Kline</i>	DATE SIGNED <b>Apr 4 1958</b>								
PHYSICIAN'S NAME (Type) <b>H. F. KLINE MD.</b>	DATE SIGNED <b>Apr 4 1958</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-7-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Hope Hill</b>	22d. LOCATION (City, town, or county) <b>Frederick Co. Md.</b>	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks 111 Frederick, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 11 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Hicks</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

81 39001145-HIGH TO THE MOUNTAINS 31175433PA

BURIAU Y. S.

APR 11 1953

PEGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4586

## CERTIFICATE OF DEATH

04558

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

4 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

d. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

FREDERICK Memorial

d. STREET ADDRESS

25 East Church Street

e. IS RESIDENCE

ON A FARM?

YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Doy

Year

April 14 1958

## 5. SEX

M

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

10 April 58

9. AGE (In years  
lost birthday)

yrs.

## 10. IF UNDER 1 YEAR

Months

## 11. IF UNDER 24 HRS.

Days

## 12. IF UNDER 24 HRS.

Hours

## 13. CITIZEN OF WHAT COUNTRY?

Min.

USA

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Infant

## 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Wallace Earl Kemp

## 14. MOTHER'S MAIDEN NAME

Virgie Irene Roderick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

## 16. SOCIAL SECURITY NO.

None

## 17. INFORMANT

Address

Hospital record

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Aggravation of the Brain

INTERVAL BETWEEN  
ONSET AND DEATH

753.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 10 April 1958, to 14 April 1958, that I last saw the deceased  
alive on 14 April 1958, and that death occurred at 9:05 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

R. L. Guest

M.D.

7 E. Church St.  
Frederick Md.PHYSICIAN'S  
NAME (Type)

R. L. Guest

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

Apr. 17, 1958

## 22c. NAME OF CEMETERY OR CREMATORI

Mount Olivet Cemetery

## 22d. LOCATION (City, town, or county)

Frederick, Maryland

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

M. R. Etchison &amp; Son, Frederick, Maryland

## 24a. REC'D BY REGISTRAR

DATE

APR 21 '58

## 24b. REGISTRAR'S SIGNATURE

A. Etchison

2069191XV4

## CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151</
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04589

## 4587 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick		MARYLAND		a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick				x Frederick--- rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Chronic Hospital					
3. NAME OF DECEASED (Type or print)		First JOHN	Middle S.	Last KING	4. DATE OF DEATH April 4th
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 81 yrs.
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 30, 1876	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Amusement Park		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
David M. King		Anna M. Deloser		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		577-14-0067		Address Arthur D. King, Thurmont, Maryland RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Lobar Pneumonia 3 days.			
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Chronic Myocarditis 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
490X 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour a. m. p. m.		19	White at work <input type="checkbox"/> at work <input type="checkbox"/>		
21. I certify that I attended the deceased from		Oct. 1, 1957 to April 4, 1958, that I last saw the deceased alive on April 4, 1958, and that death occurred at 7:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) 7 N. Market St.			
PHYSICIAN'S NAME (Type)		DATE SIGNED Dr. H. F. Kline			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)
Burial		4-8-58	Lewistown Cemetery		Lewistown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR APR 9 1958		24b. REGISTRAR'S SIGNATURE C. E. Leach
Raymond E. Creager		Thurmont, Md.			

APR 9 1959

# PRÉGÉEIV E0

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04590

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		4613 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>		c. LENGTH OF STAY IN 1b <b>Since 11/6/57</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shookstown Road</b>		d. STREET ADDRESS <b>Shookstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JULIAN</b>	Middle <b>JOSEPH</b>	Last <b>KOPFF</b>	4. DATE OF DEATH <b>April 28, 1958</b>	Month Day Year	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	b. DATE OF BIRTH <b>18 April 1904</b>	9. AGE (In years last birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Kopff</b>			14. MOTHER'S MAIDEN NAME <b>Annie Weber</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578-09-4163</b>		17. INFORMANT <b>Mrs. Mildred Kopff (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary artery thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>4-29-58</b>
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-2-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DAY 2 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>	

STATE OF SOUTH DAKOTA  
GENERAL EXAMINER'S CERTIFICATE OF DEATH

State of South Dakota

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		4588	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND			a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		2 years	// Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Frederick Memorial Hospital		102 Frederick Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last
Clyde		Anthony	Lafoon	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 4, 1943
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
14 yrs.		Student		Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
U.S.A.		Clyde Alvin		
14. MOTHER'S MAIDEN NAME		Margaret Belle Houston		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
No				Dr Cecil Houston 102 Frederick Ave
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Frederick, Md		
816X		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO		Ruptured Spleen, Fractured ribs on		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		right side, Pneumothorax		
(b)		13 hours		
DUE TO		Brain contusion		
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 10 10 p.m.		Automobile ran into back of pick up truck		
Month, Day, Year 4/3/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mr. Hyattstown (County) Frederick (State) Route 240 (Md)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)		DATE SIGNED		
B.O. Thomas, M.D.		April 5, 1958		
22a. BURIAL, CREMATION, REBURNING (Specify) BURIAL		22b. DATE THEREOF April 8, '58		22c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NATIONAL
22d. LOCATION (City, town, or county) 4101 Suitland Rd. Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE O'Dayley		ADDRESS FREDERICK, MARYLAND		24a. REC'D BY REGISTRAR DATE APR 9 '58
				24b. REGISTRAR'S SIGNATURE O'Dayley

BUREAU Y. S.

APR 9 1959

REGEV EDITIONS

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by a funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4589 CERTIFICATE OF DEATH

04592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>427 North Bentz Street</b>		d. STREET ADDRESS <b>427 North Bentz Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>HENRY</b>	Last <b>LAYMAN</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>3,</b>	Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>21 May 1888</b>	9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Works</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Clarence Layman</b>				14. MOTHER'S MAIDEN NAME <b>Katie Baumgardner</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3001</b>		17. INFORMANT <b>Mrs. Rosie Layman (Same as item #1)</b>		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronch pneumonia</i> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cardio vascular disease</i> DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>491X</p>								
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
<p>21. I certify that I attended the deceased from <b>Jan 1952</b> to <b>April 3, 1958</b> that I last saw the deceased alive on <b>April 3, 1958</b>, and that death occurred at <b>2:40 P.M.</b> from the causes and on the date stated above.</p>								
<p>ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b></p>								
<p>DATE SIGNED <b>4-4-58</b></p>								
<p>ACTUAL SIGNATURE <i>B. O. Thomas</i></p>								
<p>PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b></p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-7-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Alf. Etchison</i>		

19. **CAUSE OF DEATH** **2** **2**

## BUREAU V.

- 858 -

## REFUGEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4590

## CERTIFICATE OF DEATH

Reg. Dist. No.

04593

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. STREET ADDRESS <b>703 Rosemont Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Francis</b>	Last <b>Little</b>
4. DATE OF DEATH <b>April 23</b>	Month <b>1958</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>Married</b>	8. DATE OF BIRTH <b>July 1-1892</b>
9. AGE (In years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
13. FATHER'S NAME <b>Francis P. Little</b>	14. MOTHER'S MAIDEN NAME <b>Annie English</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>579-07-1132</b>	17. INFORMANT <b>Mrs. Wm. F. Little-703 Rosemont Ave.-Frederick-</b>	Address <b>Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>445x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Neuritis</b>			
(b) <b>Malignant hypertension</b>		3 years	
DUE TO (c) <b>Arteriosclerotic nephrosclerosis</b>		6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gastric ulcer with hemorrhage</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/1</b> , 19 <b>58</b> , to <b>4/23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/22</b> , 19 <b>58</b> , and that death occurred at <b>4:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 E. Church St.</b> DATE SIGNED <b>Henry V Chase</b>			
ACTUAL SIGNATURE	M.D.		
PHYSICIAN'S NAME (Type) <b>Dr. H.V. Chase</b>	Frederick-Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-26-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Peter's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hancock</b> (State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>	ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. Cline</b>

BUREAU V. S.

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# DECEIV ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, F11mG228 5-15-58 et

04594

4591

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Jefferson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Luther</i>		First <i>CURTIS</i>	Middle <i>MANN</i>
4. DATE OF DEATH <i>April 1 20 1958</i>	Last <i>MANN</i>	Month <i>April</i>	Day <i>20</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-6-1872</i>
9. AGE (in years on birthday) <i>80</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>CURTIS PETER MANN</i>	14. MOTHER'S MAIDEN NAME <i>LAURA VINCEL</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <i>ADDISON MANN BURKITTSVILLE Md</i>	Address <i>BURKITTSVILLE Md</i>
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Lobar Pneumonia</i>			
490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Atherosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>April 7, 1958</i> , to <i>April 20, 1958</i> , that I last saw the deceased alive on <i>April 20, 1958</i> , and that death occurred at <i>1517</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. A. Pearce</i>	M.D.	ADDRESS (Street, city or town, state) <i>Frederick, Md</i>	DATE SIGNED
PHYSICIAN'S NAME (Type) <i>A. A. PEARCE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>4-22-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>UNION</i>	22d. LOCATION (City, town, or county) <i>BURKITTSVILLE Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Feltz</i>	ADDRESS <i>Brunswick Md</i>	24a. REC'D BY REGISTRAR DATE <i>APR 28 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. E. Smith</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04595

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Emmitsburg,		c. LENGTH OF STAY IN 1b 18 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-- Emmitsburg,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#1		d. STREET ADDRESS R.D.#1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert		First William	Middle McCleaf	Lost	4. DATE OF DEATH April	Month 7	Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 2, 1904	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fairfield, Adams Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David McCleaf		14. MOTHER'S MAIDEN NAME Adeline May Keppelry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 175-03-4875		17. INFORMANT Mrs. Albert McCleaf, R.D.#1		Address Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hyper tension cardio vas. disease (c)		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1957, to <u>April 7</u> , 1958, that I last saw the deceased alive on <u>April 6</u> , 1958, and that death occurred at <u>M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE W. R. Cadle M.D.						ADDRESS (Street, city or town, state) Emmitsburg, Frederick Co., Md.	
PHYSICIAN'S NAME (Type) W. R. Cadle M.D.						DATE SIGNED 4-7-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Elias Lutheran		22d. LOCATION (City, town, or county) Emmitsburg, Frederick Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE A. L. French	
VS A15 (4) 15M 9/55				DATE			

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
APR 9 1968

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04596

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		4615 Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 Years		b. COUNTY	
Walkersville				Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
Frederick Avenue		Dublin Road		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		WILLIAM	ROBERT	McFARLAND	April 2, 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at birthday) 44 yrs.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	25 March 1914	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Painter		Instrument Co.		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward L. McFarland		Minnie Riley		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		214-14-6991		Address Mrs. Mary S. McFarland (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> <u>Acute Cardiac dilatation with</u> DUE TO <u>Conditions, if any, which</u> <u>gave rise to immediate cause</u> <u>(a), stating the underlying</u> <u>cause last.</u> (b) <u>pulmonary Edema</u> DUE TO (c) <u>Subacute Bacterial Endocarditis</u> <u>2 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 4-4-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	24a. REC'D BY REGISTRAR APR 7 '58	24b. REGISTRAR'S SIGNATURE <u>W. E. Etchison</u>	
VS. A15ME(5) 5M 9/55			DATE		

DEPARTMENT OF HEALTH - WASHINGTON, D.C.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU U.S.

APR 7 1958

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04597

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		4592		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Marlyland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 E. South Street</b>		d. STREET ADDRESS <b>10 E. South Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ira Vernal Moore</b>		First <b>Ira</b>	Middle <b>Vernal</b>	Last <b>Moore</b>	4. DATE OF DEATH <b>April 13</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1880</b>	9. AGE (In years last birthday) <b>78</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>	
13. FATHER'S NAME <b>William H. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Kahle</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Pansy Moore, 10 E. South Street, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH <b>10 Minute</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 13, 1958</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Olivet Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C E Cline &amp; Son</i>		W.		22d. LOCATION (City, town, or county) <b>Frederick- Maryland</b>	
				24a. REC'D BY REGISTRAR DATE <b>APR 15 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>W. Schaeuch</i>	

WISCONSIN STATE GOVERNMENT CERTIFICATE - BUREAU  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
WISCONSIN

REG'D TO DEATH

APR 15 1958

BUREAU V.

APR 15 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4593 CERTIFICATE OF DEATH

Reg. Dist. No. 04598

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	c. LENGTH OF STAY IN 1b <b>1 week</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Knoxville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) o. INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jacob</b>	First <b>Jacob</b>	Middle <b>Olden</b>	Last <b>Olden</b>
4. DATE OF DEATH <b>4</b>	Month <b>Month</b>	Day <b>29</b>	Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/1877</b>
9. AGE (In years lost birthday) <b>81</b>		10. IF UNDER 1 YEAR Months <b>81</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Joshua Olden</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Crouse</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>111-11-1111</b>	17. INFORMANT <b>Mrs. Melvin Phillips, Knoxville, Md.</b>	Address <b>Knoxville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO  (c)		<b>Cerebral Hemorrhage</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO  (b) <b>Hypertensive Cardiovascular Disease</b>		6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/> <b>19</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Brownsville</b>
		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>4-21</b> , 19 <b>58</b> , to <b>4-30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-30</b> , 19 <b>58</b> , and that death occurred at <b>12 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W 3rd St</b>			
DATE SIGNED <b>4-30-58</b>			
ACTUAL SIGNATURE <b>Thomas E. Stone</b>		Frederick Md.	
PHYSICIAN'S NAME (Type) <b>Dr. Thomas Stone</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ch. of Brethren Cem.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/2/1958</b>	22d. LOCATION (City, town, or county) <b>Brownsville</b>	(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>Albert E. Smith</b>	24b. REGISTRAR'S SIGNATURE <b>Albert E. Smith</b>
		DATE <b>MAY 5 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4616

## CERTIFICATE OF DEATH

Reg. Dist. No.

04599

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
FREDERICK MARYLAND		MARYLAND FIREDERICK				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 35				
BRUNSWICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRUNSWICK				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 321 EAST A. ST.				
321 EAST A. ST.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle			
ROBERT LEE ORRISON		ROBERT	LEE			
4. DATE OF DEATH		Month	Day			
APRIL 19		1958				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
MALE		WHITE		MAY 18, 1886		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
FIREMAN		B. & O. R. R.		VIRGINIA		V. S.
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME		Address		
THOMAS S. ORRISON		MARY VIRTS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
No		705-10-0009		LESLIE ORRISON		BALTIMORE, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusive Disease				
420.1						
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Coronary Occlusive Disease				
DUE TO		10 hrs				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr 19, 1958</u> to <u>Apr 19, 1958</u> , that I last saw the deceased alive on <u>Apr 19, 1958</u> and that death occurred at <u>68</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE		M.D. <u>J. G. F. Smith</u> DATE SIGNED <u>Apr 19, 1958</u>				
PHYSICIAN'S NAME (Type)		BRUNSWICK, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) LOVETTSVILLE, VA. (State)
BURIAL		APR 22/58		UNION CEMETERY		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
B. Lee Feltz Brunswick, Maryland				APR 22 '58		<u>Lee Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED
RECEIVED						
APR 22 1953						
BUREAU V. S						

RECEIVED  
APR 22 1953

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04600

Reg. Dist. No.

4594

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Pennsylvania Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WALTER</b>	Middle <b>HENRY</b>	Last <b>PHEBUS, SR.</b>
4. DATE OF DEATH	Month <b>April</b>	Day <b>10</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 April 1901</b>
9. AGE (In years to last birthday) <b>56</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>County Roads</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>E. McClellan Phebus</b>	14. MOTHER'S MAIDEN NAME <b>Margaret V. (last name unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>220-09-4398</b>	17. INFORMANT <b>George E. Phebus, Address 800 Montclair Avenue, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Strangulation by 974X</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hanging</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Frederick</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	DATE SIGNED <b>4-11-58</b>		
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-14-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>APR 14 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Al. Etchison</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE GOVERNMENT - DEPARTMENT OF MEDICAL EXAMINER - CERTIFICATE OF DEATH

BUREAU X

APR 14 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4595

## CERTIFICATE OF DEATH

Reg. Dist. No.

04601

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>9 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sellman</b>		d. STREET ADDRESS <i>15x2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Wilson</b>	Middle <b>Clarke</b>	Last <b>Poole</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>2</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 15-1896</b>	9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>61</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Active farm owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Algie Poole</b>				14. MOTHER'S MAIDEN NAME <b>Mary Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-36-1923</b>		17. INFORMANT <b>Mrs Wilson Poole, Sellman Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Argyrophilic Lateral Sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>13 April</i> , 1958, to <i>2 April</i> , 1958, that I last saw the deceased alive on <i>9 April</i> , 1958, and that death occurred at <i>12:30</i> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Barnesville, Md</i> DATE SIGNED <i>2 April 58</i>							
ACTUAL SIGNATURE <i>Gordon M. Smith</i>		M.D.					
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hillen, Barnesville, Md</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 7 '58</b>	
						24b. REGISTRAR'S SIGNATURE <i>Al Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

81 2000 RELEASE UNDER E.O. 14176

URÉAU Y.

APR 7 1958

REGELY ED 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4596

## CERTIFICATE OF DEATH

Reg. Dist. No.

04602

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>70 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>125 West Third St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crutchley Nursing Home -708 N.Mkt. St.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Martha</b>		First <b>C.</b>	Middle <b>Quinn</b>	Lost	4. DATE OF DEATH <b>April 28</b>	Month <b>April</b>	Day <b>28</b>	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>XXXXXX</del> <b>WIDOWED</b>	8. DATE OF BIRTH <b>July 30-1871</b>	9. AGE (In years lost birthday) <b>86</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George H. Dutrow</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Harper</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Thomas Jackson-811 Motter Ave., Frederick-</b>		Address <b>Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute Cholelithiasis</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>4-8</b> , 19 <b>58</b> , to <b>4-28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-28</b> , 19 <b>58</b> , and that death occurred at <b>10:40PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 West Third St.</b> DATE SIGNED <b>4-30-58</b>								
ACTUAL SIGNATURE <b>Thomas E. Stone</b>		M.D. <b>Frederick- Maryland</b>						
PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Stone</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 1 58</b>		24b. REGISTRAR'S SIGNATURE <b>Alvin Schuck</b>		

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Date of Death

Place of Death

Name of Hospital

Name of Doctor

Name

Name

Signature

Signature

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4617 CERTIFICATE OF DEATH

Reg. Dist. No.

04603

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie		First	Middle	lost	4. DATE OF DEATH Month 4	Day 14	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/1866		9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua Norris				14. MOTHER'S MAIDEN NAME Catherine McBride			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Weldon Ray, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Arteriosclerosis Heart Disease e Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 12:30 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE J. E. Harp		M.D.		Middletown		DATE SIGNED Apr 14 58	
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/17/1958		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 18 '58		24b. REGISTRAR'S SIGNATURE Q. Harp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1811 CERTIFICATE OF DEATH

BUREAU V. S

APR 10 1953

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04604

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for our files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		4618										2	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>										<b>Reg. Dist. No.</b> <b>04604</b>	
Rural Middletown		30 years		<b>X</b> Rural Middletown d. STREET ADDRESS <b>/</b>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Jacob Howard Schroyer</b>		First	Middle	Last	<b>4. DATE OF DEATH</b> <b>4 4 1958</b>		Month	Day	Year	<b>e. IS RESIDENCE ON A FARM?</b> <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/1/1895</b>		<b>9. AGE (In years last birthday)</b> <b>63</b> yrs.		<b>10. IF UNDER 1 YEAR</b> <b>Months Days Hours Min.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farm owner</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>							
<b>13. FATHER'S NAME</b> <b>John F. Schroyer</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella Dusing</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>W.W.I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-36-4347</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Schroyer, Middletown, Md.</b>		<b>Address</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b>											
PART I. DEATH WAS CAUSED BY: <b>IMMEDIATE CAUSE (a)</b> <b>420.1</b>		<b>Coronary Occlusion</b>											
Conditions, if any, which gave rise to immediate cause <b>(a), stating the underlying cause last.</b>		<b>(b)</b> <b>DUE TO</b> <b>(c)</b>											
<b>20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b>		<b>Natural causes <input checked="" type="checkbox"/></b> , <b>Accident <input type="checkbox"/></b> , <b>Suicide <input type="checkbox"/></b> , <b>Homicide <input type="checkbox"/></b> , <b>Undetermined manner <input type="checkbox"/></b>											
<b>ACTUAL SIGNATURE</b> <b>Dr. James B. Thomas</b>		<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>										<b>DATE SIGNED</b> <b>4/4/58</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>22b. DATE THEREOF</b> <b>4/8/1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Lutheran Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Middletown, Md.</b>		<b>(State)</b>		<b>24a. REC'D BY REGISTRAR</b> <b>APR 9 '58</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Gladhill Company, Middletown, Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>John</b>											
<b>VS. A15ME 5M 2/57</b>		<b>DATE</b>											

WISCONSIN STATE CHARTERED  
WISCONSIN STATE EXAMINER'S CERTIFICATE OF DEATH

STATE REG.  
REG. NO. 1000

EXPIRES 10/31/

BUREAU K-1

APR 9 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4619 CERTIFICATE OF DEATH

Reg. Dist. No. 04605

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville		c. LENGTH OF STAY IN 1b 67 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOHN	Middle WILLIAM	Last SMITH	4. DATE OF DEATH April 29, 1958	Month April	Day 29	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 May 1884	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY School Bus		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John F. Smith		14. MOTHER'S MAIDEN NAME Clara Jane Dertzbaugh						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-0699		17. INFORMANT Mrs. Mary E. Smith (Same As Item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 15 Min.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		Cerebro Vascular Thrombosis						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		Arterio Sclerosis				10 years		
DUE TO } (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Pyonephrosis due to urethral stricture						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June 1, 1956</u> , to <u>April 29, 1958</u> , that I last saw the deceased alive on <u>April 28, 1958</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ralph L. Michels</u>						ADDRESS (Street, city or town, state) M.D. Shopping Center		
PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D.						DATE SIGNED 4-30-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 2 '58		24b. REGISTRAR'S SIGNATURE <u>Asleach</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04606

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.F.D.#6</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>Bartonsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ARTHUR</b>		First <b>JACOB</b>	Middle <b>STAUB</b>	Last <b>STAUB</b>	4. DATE OF DEATH <b>April</b>	Month <b>12</b>	Day <b>1958</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1907</b>	9. AGE (In years lost birthday) yrs. <b>51</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>No.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Calvin Staub</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Eiswalt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-7504</b>		17. INFORMANT <b>Mrs/ Edith V. Staub, Same as Item #2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung abscess</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>								
493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Pneumonia</b> 2 weeks DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>Pulmonary emphysema</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>January, 1958</b> , to <b>April 12, 1958</b> , that I last saw the deceased alive on <b>April 12, 1958</b> , and that death occurred at <b>12:00A</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Ralph L. Michels M.D.</b> M.D. Frederick, Maryland								
PHYSICIAN'S NAME (Type) <b>Dr. R. L. Michels</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>4597</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

MAY 1965

RECEIVED  
APR 15 1969  
BUREAU V. S

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4598 CERTIFICATE OF DEATH

Reg. Dist. No.

04607

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Since 4/2/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Bartonsville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDITH	Middle ELEANOR	Last STAUFFER
4. DATE OF DEATH	Month April	Day 7,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Aug 1894
9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter Cockrell	14. MOTHER'S MAIDEN NAME Lillie Hoffman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT H. G. Stauffer (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 260X		(b) <i>Hypertension Cardiovascular disease</i> 10 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. <i>Diabetes mellitus</i> 2. <i>Bronchopneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1. <i>Diabetes mellitus</i> 2. <i>Bronchopneumonia</i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/2</i> , 1958, to <i>4/6</i> , 1958, that I last saw the deceased alive on <i>4/6</i> , 1958, and that death occurred at <i>6:20A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry V. Chase</i> ADDRESS (Street, city or town, state) M.D. 4 E. Church St. DATE SIGNED 4-7-58			
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-9-58	22c. NAME OF CEMETERY OR CREMATORIUM Glade Cemetery	22d. LOCATION (City, town, or county) Walkersville, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D. BY REGISTRAR APR 9 '58	24b. REGISTRAR'S SIGNATURE <i>John Smith</i>

## CERTIFICATE OF DEATH

BUREAU V. 8

APR 9 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Dickerson R.F.D. 15 x - 2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Clarence	Middle Foglieman	Last Steele	4. DATE OF DEATH April	Month 18	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1896	9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months Hours	11. IF UNDER 24 HRS. Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Steele		14. MOTHER'S MARRIED NAME Genevieve Crabtree					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes I		16. SOCIAL SECURITY NO. World war 215-36-5472		17. INFORMANT William Hilton, Barnsville Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hemorrhage of brain due to self inflicted <del>gun</del> gun shot wound of skull and brain INTERVAL BETWEEN ONSET AND DEATH I 1/2 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMAR <del>Y</del> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self thruu skull and brain					
20c. TIME OF INJURY 5-15 <del>xx</del> p.m. 4/18/58		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 107		20f. (City or town) Nr Dickerson	(County) Montgomery, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 19, 1958					
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy					
22b. BURIAL, CREMATION, REMOVAL (Specify) 4/21/58		22d. LOCATION (City, town, or county) Beallsville, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnsville Md.		24a. REC'D BY REGISTRAR APR 22 '58					
		24b. REGISTRAR'S SIGNATURE C. L. couch					

RECEIVED  
BUREAU Y. S.

APR 22 1953

STATE

18  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04609

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4620 Frederick	MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		8 years	c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R.D.#1		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years from birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		80 yrs.	Months	Days	Hours	Min.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
Spanish American War		290-10-5372		Waltie D Odem, Emmitsburg Rd I						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis		10 minutes						
480.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)								
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Doy, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 23 1958				
EXAMINER'S NAME (Type) B. O. Thomas		22b. DATE THEREOF 4/25/1958		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland				
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. ADDRESS Emmitsburg, Md.		24e. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE Allie L. Allie				
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison										

MANHATTAN STATE PENITENTIARY - ALBANY, N.Y.  
MEDICAL EXAMINER CERTIFICATE OF DEATH

BUREAU U. S.

APR 25 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4621 CERTIFICATE OF DEATH

04610

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Myersville</b>		c. LENGTH OF STAY IN 1b <b>32 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Myersville</b>	
3. NAME OF DECEASED (Type or print) <b>CHESTER</b>		First <b>FRANKLIN</b>	Middle <b>SUMMERS</b>
4. DATE OF DEATH Month <b>April</b>	Day <b>19</b>	Year <b>1958</b>	5. SEX male
6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 23, 1894</b>	9. AGE (In years lost birthday) <b>63</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own General Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Myersville, Fred. Co. Md. U.S.A.</b>
13. FATHER'S NAME <b>William H. Summers</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Brandenburg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>215-36-7047</b>	17. INFORMANT <b>C. Albert Summers, Myersville, Md. Rt. #1</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Hypertension</b> <b>235</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Myersville</b>	(County) <b>Md.</b>	(State) <b>U.S.A.</b>	
21. I certify that I attended the deceased from <b>6-1</b> , 19 <b>57</b> , to <b>4-18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-18</b> , 19 <b>58</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>U. G. Bourne Jr.</i>	ADDRESS (Street, city or town, state) <b>Myersville, Md.</b>		DATE SIGNED <b>4/21/58</b>
PHYSICIAN'S NAME (Type) <b>U. G. Bourne, 30 W. All Saints St, Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 22, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Paul's Lutheran</b>	22d. LOCATION (City, town, or county) <b>Myersville, Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>	ADDRESS <b>Myersville, Md.</b>	24a. REC'D BY REGISTRAR <b>APR 23 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Ab. esch</i>

BUREAU X-5

APR 23 1958

REVIEW  
APR 23 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4600

## CERTIFICATE OF DEATH

Reg. Dist. No.

04611

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 17 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 East Fifth Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3	
3. NAME OF DECEASED (Type or print) AMANDA		d. STREET ADDRESS Utica	
First MIDDLE Last		4. DATE OF DEATH Month April Day 25, Year 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 15 April 1867	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (in years last birthday) 91		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew J. Wachter		14. MOTHER'S MAIDEN NAME Cornelia Coblentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Blanche R. Kline (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Chronic glomerulonephritis (c)		INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 5:30P M, from the causes and on the date stated above. ACTUAL SIGNATURE James B. Thomas PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 4-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-58	
22c. NAME OF CEMETERY OR CREMATORIUM Utica Cemetery		22d. LOCATION (City, town, or county) Frederick County Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 29 '58	
		24b. REGISTRAR'S SIGNATURE Albert E. Etchison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## CERTIFICATE OF DEATH

DEATH CERTIFICATE NUMBER	NAME OF DECEASED	SEX	AGE	CAUSE OF DEATH	DEATH DATE	DEATH PLACE	REGISTRATION NUMBER
123456789	John Doe	Male	55	Heart Disease	1939-04-29	Hospital	123456789
DEATH CERTIFICATE NUMBER: 123456789							
NAME OF DECEASED: John Doe							
SEX: Male							
AGE: 55							
CAUSE OF DEATH: Heart Disease							
DEATH DATE: 1939-04-29							
DEATH PLACE: Hospital							
REGISTRATION NUMBER: 123456789							

BUREAU Y.

APR 29 1939

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04612

## 4601 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEM. HOSP.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Hook (Rural)</u>	
d. STREET ADDRESS <u>R.F.D. #1, Knoxville, Md.</u>		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LUNA</u> First <u>BLANCHE</u> Middle		4. DATE OF DEATH <u>APRIL 26 1958</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 APRIL 1876</u>	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Loudoun County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Elisha Webb</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Butts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George Marvin Watters</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart dis.</u> (c) <u>15 yrs (±)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260x Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>(County)</u> <u>(State)</u>	
21. I certify that I attended the deceased from <u>1951</u> to <u>4/26 1958</u> that I last saw the deceased alive on <u>26 April 1958</u> , and that death occurred at <u>12:23 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Conley, Jr.</u>		ADDRESS (Street, city or town, state) <u>M.D. PROFESSIONAL BLDG., FREDERICK, MARYLAND</u> DATE SIGNED <u>4/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Brethren Cemetery</u>		22d. LOCATION (City, town, or county) <u>Brownsville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald C. Conley</u>		ADDRESS <u>Harper Ferry West Va.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	
DATE <u>APR 29 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BUREAU V. S.

APR 29 1959

PEGEIY EO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4622 CERTIFICATE OF DEATH

04613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN lb Since 4/3/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 25 East Church Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) Vindobona Convalescent & Rest Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ADDIE	Middle C.	Lost WEAVER	4. DATE OF DEATH April	Month 7,	Day 19	Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH 3 Jan 1882	9. AGE (In years lost/birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME L. V. Stephens				14. MOTHER'S MAIDEN NAME Anna B. Durrette					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary W. Young, Frederick, Md.		112 E. Church St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x <i>Acute Cardiac Fibrillation</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO <i>1 hour</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cardio-Vascular Renal Disease</i> 7 years DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491x <i>Brunko Pneumonia</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County)	(State)
21. I certify that I attended the deceased from <i>Aug</i> , 1958, to <i>April 7</i> , 1958, that I last saw the deceased alive on <i>April 6</i> , 1958, and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. L. Fahrney</i> ADDRESS (Street, city or town, state) M.D. 17 E. Second St.		DATE SIGNED 4-7-48							
PHYSICIAN'S NAME (Type) H. L. Fahrney, M.D.		<i>Frederick Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-7-58		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory		22d. LOCATION (City, town, or county) Washington, D. C. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Alvin Etchison</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4623

## CERTIFICATE OF DEATH

Reg. Dist. No.

04614

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Connecticut</b>		b. COUNTY <b>Tolland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stafford</b>		45 x -3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELEANOR</b>		First	Middle	Last	4. DATE OF DEATH <b>April 6 1958</b>	Month	Day	Year	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 8, 1886</b>	9. AGE (In years last birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Schoolteacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Ware, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edward Albright</b>				14. MOTHER'S MAIDEN NAME <b>Elmer C. Hurlburt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>6-----</b>		17. INFORMANT <b>Mrs. Elliott Haines, Myersville, Md. Rt. #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b>		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Carcinoma of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>					
b) DUE TO  c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from <b>Oct 4, 1957</b> to <b>Oct 6, 1958</b> , that I last saw the deceased alive on <b>Oct 4, 1958</b> , and that death occurred at <b>535 Main St., Middletown, Md.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Middletown</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>Elmer Harp</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>		Middletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>Apr. 7, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Stafford Springs</b>		22d. LOCATION (City, town, or county) <b>Connecticut</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 8 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Bittle</b>			

## CERTIFICATE OF DEATH

Name of deceased		Name of physician	
John J. O'Conor		John J. O'Conor	
Age at death		Cause of death	
67 yrs		Diseased heart	
Place of death		Name of hospital	
Home		John Hopkins Hospital	
Date of birth		Date of death	
1891-08-15		1958-04-08	
Place of burial		Name of funeral director	
Cemetery		John J. O'Conor	
Signature of physician		Signature of coroner	
John J. O'Conor		John J. O'Conor	
APR 8 1958		APR 8 1958	

BUREAU X

APR 8 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4602 CERTIFICATE OF DEATH

Reg. Dist. No.

04615

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>1011 North Market Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>HATTIE</b>	Middle <b>HIMBURY</b>	Last <b>YOUNG</b>	4. DATE OF DEATH <b>April 13, 1958</b>	Month <b>April</b>	Day <b>13</b>	Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1867</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Issachar Himbury</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Hooper</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Alton Y. Bennett, Same as Item #2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myositis</b> DUE TO <b>422.2</b> <b>2410.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO <b>5705.</b> (c) <b> </b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>April 12, 1958</b> , to <b>April 13, 1958</b> , that I last saw the deceased alive on <b>April 12, 1958</b> , and that death occurred at <b>12:06 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North Market Street</b> DATE SIGNED <b>4/15/58</b>								
ACTUAL SIGNATURE <b>H. F. Kline</b>								
PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b> Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 16, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			ADDRESS			24a. REC'D BY REGISTRAR DATE <b>APR 16 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. L. French</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

WISCONSIN STATE GOVERNMENT OF HENDRY - SUBMORGE DS

REC'D. CERTIFICATE OF DEATH

RECEIVED

DEATH

DEATH CERTIFICATE

BUREAU V. S.

APR 16 1953

RECEIVED